PRISM HEALTH

SLIDING FEE DISCOUNT PROGRAM

Who qualifies for the Sliding Fee Discount Program?

Eligibility for this program is based on financial need which is determined using the Federal Poverty Level (FPL) Guideline. Applicants are required to provide proof of household income and family size. **All information is confidential.** This information is used to calculate an applicant's FPL. Those whose household size and annual income puts them at or below 200% of the FPL will qualify for the Sliding Fee Discount Program.

New or established patients can apply for the Sliding Fee Discount Program at any time. All patients are required to provide annual income and household size information once every 365 days. However, you may request an update of income, household size or medical insurance status as it changes.

Sliding Fee Discount Program approval is good for one year. It is the patient's responsibility to maintain coverage under this program and renew 45-days in advance of coverage expiration.

Why does Prism Health need to know household income?

As a Federally Qualified Health Center (FQHC), Prism Health is required to use the Federal Poverty Level (FPL) Guideline to determine eligibility for the Sliding Fee Discount Program. FPL is determined by annual income and number in household. Federal guidelines define household size and income specifically as:

Definition of Household: Household size must include:

- the patient
- the patient's spouse, domestic partner, or partner
- and the number of dependent children (even if they do not live with the patient/applicant)

Definition of Income: Income is defined as total cash on hand before taxes from all sources, which can include:

- Wages and salaries
- Receipts from self-employment after deductions for normal operating expenses
- Regular payments through public assistance, social security, longevity, unemployment, strike benefits, military allotments, disability, rental income, regular support from an absent family member or someone not living in the household (includes child support), government or private pensions, and regular insurance or annuity payments
- Income from dividends (including permanent fund), interest, rent royalties, or income from estates or trusts

Nominal Fees:

A nominal fee is a fee that is far below the real value or cost of a service or services. Patients whose FPL is at or below 100% of the Federal Poverty Guideline will be charged only a nominal fee for their services at Prism Health: $25.00 for medical visits (includes primary medical care) and $10 for behavioral health visits. The nominal fee is not a threshold for receiving care and thus, is not a minimum fee or co-payment. Patients who qualify for the Sliding Fee Discount Program will receive services at a discounted rate that is assigned by Prism Health and correlates to their FPL (see below). Prism Health staff will determine the discounted rate. Approval for the Sliding Fee Discount Program and the qualifying discount rate will be sent to the patient through MyChart.

PRISM HEALTH

Prism Health Sliding Fee Discount Schedule

	0-100% FPL	101%-133%	134%-166%	167%-200%	> = 200% FPL
Medical Visit	$25 Nominal Charge	$35	$40	$45	Full Payment
Behavioral Health	$10 Nominal Charge	$15	$20	$25	Full Payment
Pharmacy	$10 Nominal Charge	$15	$20	$25	Full Payment

Avita Pharmacy Sliding Fee Discount Schedule

Prism Health's pharmacy partner, Avita Pharmacy, honors Prism's Sliding Fee Discount Program rates. Patients who are approved for the discount program will see the following discounted rates, based on the patient's FPL.

	0-100% FPL	101%-133%	134%-166%	167%-200%	> = 200% FPL
Avita Pharmacy	$10 Nominal Charge	$15	$20	$25	Full Payment

Quest Diagnostic Negotiated Discount Rates

Prism Health's diagnostic laboratory partner, Quest Diagnostics, honors Prism's Sliding Fee Discount Program rates. Patients who are approved for the discount program will see the following discounted rates, based on the patient's FPL. Patients who are not approved for Prism Health's Sliding Fee Discount Program and are uninsured may apply for Quest Diagnostics' financial assistance programs directly through Quest.

	0-100% FPL	101%-133%	134%-166%	167%-200%	> = 200% FPL
Quest Diagnostic Discount Percentage for Each Date of Service	100% Covered (0% patient responsibility)	75% Discount (25% patient responsibility)	50% Discount (50% patient responsibility)	25% Discount (75% patient responsibility)	No Discount (100% patient responsibility)

Rayus Radiology Negotiated Discount Rates

	0-100% FPL	101%-133%	134%-166%	167%-200%	> = 200% FPL
Cost Per Imaging Order	$25 Nominal Charge	$35	$40	$45	Full Payment

NOTE: Quest Diagnostics, Avita Pharmacy, and Rayus Radiology bill patients independently from Prism Health. Any billing and charges issues with these external partners should be directed to them first.

PRISM HEALTH

SLIDING FEE DISCOUNT PROGRAM APPLICATION

Patient Name: _____ **Today's Date:** _____

Name of Responsible Party (if it is not the patient): _____

Proof of income must be provided to qualify for the Sliding Fee Discount Program. This information must be updated at least annually, and any time your household income size and/or medical insurance status changes. Failure to provide Prism Health with information regarding any changes in your household, income, or insurance status will result in a suspension and possibly termination from the Sliding Fee Discount Program.

Proof of income includes:

- **Pay Stubs** - Documentation of two concurrent months' worth of income.
- **Letter from Employer** – Dated within the last 6 months
- ed within last 6 months, verifying income.
- **Tax Documents** – Tax return from previous tax year or previous year's W2
- **Current Award/Benefit Letter** – E.g., Social Security, Pension, etc.
- **Zero Income Statement** – If you do not have any income, from any source, you can ask to sign a Zero Income Statement.

Household Members

List your name and the names of ALL individuals in your household including dependent children.

Name	Relationship to Applicant	Age	Date of Birth	Annual Income	Employed	Unemployed
	SELF					

If you need more space, please continue on the back of this form.

Your Income

If you are working, please select the frequency you are paid and list the amount you are paid: (select ONE)

I am paid WEEKLY, and I make this much each week:	**I am paid BIWEEKLY, and I make this much every two weeks:**	**I am paid MONTHLY, and I make this much each month:**	**I am paid ANNUALLY, and I make this much each year:**

If you are not working, how are you meeting your monthly expenses?

D Savings D Borrowing D Other_____

Please check YES or NO next to the source(s) of income listed below that you and those in your household are receiving. If you select YES, please list the total amount received from that source.			
	Yes	**No**	**Amount per month**
Salary or Wages	☐	☐	
Unemployment	☐	☐	
Social Security	☐	☐	
Pension/Retirement	☐	☐	
Rental Income/Dividends	☐	☐	
Interest	☐	☐	
Spousal Support	☐	☐	
Child Support	☐	☐	
Foster Care	☐	☐	
Public Assistance (ATAP)	☐	☐	
Permanent Fund	☐	☐	
Self-Employed (net amt)	☐	☐	
Worker's Comp Benefits	☐	☐	
Disability Benefits	☐	☐	
Other	☐	☐	

Total Monthly/Annual Household Income:_____

I certify that the statements regarding the persons and income in my household are true and correct to the best of my knowledge. I further understand if any information is found to be inaccurate, I may be denied a discount and/or subject to legal action for knowingly providing false information. I agree to notify Prism Health of all changes in income, address, living arrangements, number of household members, and/or other circumstances. I understand that the information given above will be kept confidential. I also understand that if I do not agree with any decision made concerning this application, I have the right to ask in writing for a review by the Director of Healthcare Operations.

I understand that Prism Health does not bill for lab fees, and these fees will be billed separately by Quest Diagnostics. To check the price of a specific lab test, or to inquire about Quest's financial services call 800-779-8857)

Applicant Signature: _____

Applicant Printed Name: _____

Thank you!

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Application Receipt Information					
Date application received:		How was the application received?	____ Mail ____ Email ____ In-Person ____ MyChart		
Who received the application?			Date patient notified that their SFDP application was received:		
Income Calculation					
Frequency the applicant is paid		Multiplied by the number listed below	Total Annual Income	[redacted]	
Amount Paid Weekly =		x 52 Weeks=			
Amount Paid Biweekly =		x 26 Weeks =			
Amount Paid Monthly =		x 12 Months =			
Amount Paid Annually =		[redacted]			
Proof of Income					
What proof of income was provided?	___ Paystubs ____ W-2 ____ Taxes ____ Employer Letter ____ Award Letter ___ Zero Income Statement				
FPL Calculation & Approval Determination					
Number in Household:		Total Annual Income:		Patient FPL:	
Approved or Not Approved:		Medical Visit Discount Rate:		BH Visit Discount Rate:	
Staff					
Application/ documentation and calculation/ determination done by:			Calculations and determination v**erified** by:		
Date award notification sent:		Award notification sent via:	___ MyChart ___ Email ___ Postal Mail		